Declining Medicare PLUS Blue Group Coverage
OPT-OUT FORM

Please note: **If you, as the contract holder, decide to opt-out of the Medicare Advantage plan, everyone on your health care contract (all of your Medicare and non-Medicare eligible dependents) will also be removed, and WILL NOT have coverage through the State of Michigan's State Health Plan.**

If we receive your form indicating that you or a dependent does not want to be covered by the Medicare Advantage plan through the State Health Plan, we will contact you for verification.

Complete and submit the Opt-Out Form on the reverse side of this page to BCBSM.

If you still want to **decline** the State Health Plan's Medicare Advantage coverage for yourself or for your Medicare-eligible dependent, please provide the required information on the reverse side of this form.

Return this form in the postage-paid envelope no later than November 19, 2007. Only return this form if you or a Medicare-eligible dependent does not want to be covered by the Medicare Advantage plan offered through the State Health Plan.

Return the form in the enclosed postage-paid envelope to:

Blue Cross Blue Shield of Michigan
600 Lafayette East
Mail code: B491
Detroit, Michigan 48226

If you have any questions concerning this form, please contact the Medicare Plus Blue Group Customer Service at 1-888-322-5557, TTY/TDD 1-800 579-0235, 8:30 a.m. to 5:00 p.m. EST, Monday through Friday.

State of Michigan
Medicare Advantage
Medicare PLUS Blue Group [sm]
Opt-Out Form

If you wish to decline coverage:
Return this form in the postage-paid addressed envelope, or mail to:
Blue Cross Blue Shield of Michigan
600 Lafayette East, Mail code: B491
Detroit, Michigan 48226

Complete and return this form by November 19, 2007

NAME: _____ CONTRACT NUMBER: _____
PLEASE PRINT

By completing and returning this form, I am declining the Medicare Advantage plan offered to me and/or my Medicare-eligible dependent(s) by the State Health Plan.

I am aware that by deciding not to accept this Medicare Advantage coverage offered through the State Health Plan:

- My dependent or I **will not** have health benefits covered by the State Health Plan.
- My dependent or I **will not** have prescription drug or mental health/substance abuse coverage under the State Health Plan.
- My dependent or I **will only** be covered by Original Medicare.

I also understand that if I, as the contract holder, decide to opt out of the Medicare Advantage plan, all of my Medicare and non-Medicare eligible dependents will also be removed from my State Health Plan coverage.
I am the contract holder and I am declining this Medicare Advantage plan.
Please Print in Ink

Contract Holder's Last Name First Name Middle Initial			Contract Number
Sex ☐ Male ☐ Female	Birth Date	Social Security Number	Phone Number ( )

Medicare requires that an individual can only be covered under one Medicare Advantage plan. If you are also covered under a Medicare Advantage plan under your spouse's insurance, you will need to choose which plan you wish to remain enrolled. Please complete the information below to cancel dependent coverage through the State's Medicare Advantage plan.
I wish to cancel only my dependent's coverage under this Medicare Advantage plan.

Dependent's Last Name First Name Middle Initial			Contract Number
Sex ☐ Male ☐ Female	Birth Date	Social Security Number	Phone Number ( )

Dependent's Last Name First Name Middle Initial			Contract Number
Sex ☐ Male ☐ Female	Birth Date	Social Security Number	Phone Number ( )

Contract Holder's Signature*_____Date_____

Print Name Here_____

**Or the signature of the person authorized to act on behalf of the individual under the laws of the state in which the individual resides. If signed by an authorized individual, this signature certifies that: 1) this person is authorized under state law to complete this opt-out form and 2) documentation of this authority is available upon request.*

If you are the authorized representative, you must provide the following information:

Name_____
Address_____
Phone Number (____)_____
Relationship to Retiree_____